MUNISING MEMORIAL
HOSPITAL & HEALTH SERVICES

FINANCIAL ASSISTANCE APPLICATION

Munising Memorial Hospital is committed to providing financial assistance to individuals whose income and assets are such that payment is simply not possible. If you have less than $100,000 in net assets and your total household income falls below the levels shown on page 3, you may be eligible for complete or partial reduction of fees.

PATIENT INFORMATION

Name: ______________________________ Visit ID No.: ____________

Physical Address: ______________________________
(Street) (City) (State) (ZIP)

Mailing Address: ______________________________
(Street or P.O. Box) (City) (State) (ZIP)

Social Security No.: ____________________ Date of Birth: ____________________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Check Employment Status: ☐Self ☐Retired ☐Disabled ☐Unemployed ☐Student ☐Dependent

Patient's Employer: ____________________Occupation: ________ Employed Since: ______

Employer's Address ______________________________ Phone: ____________

Total Monthly Income $______________ Other Household Income $______________/Month

Source of Other Household Income: ☐Spouse ☐Alimony ☐Child Support ☐Other ______________

GUARANTOR INFORMATION (If patient not responsible, must be included below)

Name: ______________________________Relationship: ____________

Mailing Address: ______________________________
(Street) (City) (State) (ZIP)

Social Security No.: ____________________ Date of Birth: ____________________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Check Employment Status: ☐Self ☐Retired ☐Disabled ☐Unemployed ☐Student ☐Dependent

Guarantor's Employer: ____________________Occupation: ________ Employed Since: ______

Employer's Address ______________________________ Phone: ____________

Total Monthly Income $______________ Other Household Income $______________/Month

Source of Other Household Income: ☐Spouse ☐Alimony ☐Child Support ☐Other ______________

Medicaid Application Date: __________ Reason for Denial: ______________________________
(Attach copy of denial)

Medicaid Spend-down Amount (if any): $______________________________

GENERAL INFORMATION (List all people living in the household and their relationship to applicant.):

Name	Relationship
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

FINANCIAL INFORMATION:

Primary Bank/Credit Union: ______________________________ Phone: ____________________

Address____
(Street or P.O. Box) (City) (State) (ZIP)

Checking Account Balance: $____________ Savings Account Balance: $____________ Other Account(s): $____________

Do you own your home? ☐Yes ☐No Current SEV (from tax bill): $______________ Mortgage Balance: $______________

Other Real Estate Owned – Description: ______________________________ Approximate Value: $______________

AUTOMOBILES:

Make:______________ Model:________________ Year:________ Loan Balance: $______________

Make:______________ Model:________________ Year:________ Loan Balance: $______________

Other Vehicles Owned:________________________ Recreational Vehicles:________________________

I hereby certify that the above information is true and correct. I authorize Munising Memorial Hospital to contact the employers and institutions listed on this application to verify its accuracy, if deemed necessary. I further authorize the employers/institutions to release such information to Munising Memorial Hospital.

Patient Signature: ____ Date: __________________

Spouse or Legal Guardian: ____________________________________ Date: __________________

Financial assistance application must be filled out completely with all information listed and signed by patient or legal guardian and spouse, if applicable.

The following information must be provided with the completed application for assistance to be determined:

- **Copy of Medicaid approval or denial notice**
- **Pay stubs for the past 3 months (supporting all household income)**
- **Copy of most recently filed federal income tax return**
- **Copy of W-2(s)**
- **Bank statement(s), statements from any other investments**

Additional comments supporting financial assistance need:

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Munising Memorial Hospital

SLIDING FEE SCALE - FINANCIAL ASSISTANCE

Based on 2017 Federal Poverty Guidelines

	100% Discount		80% Discount		60% Discount		40% Discount		20% Discount	
Family Size	Above	Below	Above	Below	Above	Below	Above	Below	Above	Below
1	$0	$12,060	$12,061	$15,075	$15,076	$18,090	$18,091	$21,105	$21,106	$24,120
2	$0	$16,200	$16,201	$20,250	$20,251	$24,300	$24,301	$28,350	$28,351	$32,400
3	$0	$20,340	$20,341	$25,425	$25,426	$30,510	$30,511	$35,595	$35,596	$40,680
4	$0	$24,480	$24,481	$30,600	$30,601	$36,720	$36,721	$42,840	$42,841	$48,960
5	$0	$28,620	$28,621	$35,775	$35,776	$42,930	$42,931	$50,085	$50,086	$57,240
6	$0	$32,760	$32,761	$40,950	$40,951	$49,140	$49,141	$57,330	$57,331	$65,520
7	$0	$36,910	$36,911	$46,138	$46,139	$55,365	$55,366	$64,593	$64,594	$73,820
8	$0	$41,070	$41,071	$51,338	$51,339	$61,605	$61,606	$71,873	$71,874	$82,140
9	$0	$45,240	$45,241	$56,550	$56,551	$67,860	$67,861	$79,170	$79,171	$90,480
10	$0	$49,420	$49,421	$61,775	$61,776	$74,130	$74,131	$86,485	$86,486	$98,840
% of Poverty	100%		125%		150%		175%		200%	

Please return completed application to: Munising Memorial Hosptial
Attn: Financial Assistance
1500 Sand Point Road
Munising, MI 49862